EQUALITY IMPACT ASSESSMENT

HOSPITALS – CREATING A NETWORK FOR BETTER OUTCOMES

NORTHERN IRELAND

OCTOBER 2024

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Department of
Health
www.health-ni.gov.uk

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Consultation Announcement

This document is being presented as part of a full public consultation engagement exercise. It reports the outcome of a draft Equality Impact Assessment (EQIA) by the Department and comments are welcomed.

This is a draft EQIA, DoH will continue to identify equality impacts throughout the progress of the consultation and beyond. If you feel that potential impacts are not included please respond to the consultation or get in touch with us using the email address below.

Requests for versions of the EQIA in accessible formats will also be considered.

Consultation on the EQIA will end on the **28 February 2025**.

We hope that you will find time to comment on this document.

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Contact

You can contact us by email at: rebuildinghsc.services@health-ni.gov.uk please or by post at:

Transformation Branch
Regional Health Services Transformation Directorate
Department of Health NI
Annex 3, Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ
Northern Ireland

Accessibility statement

Any request for the document in another format or language will be considered.

1.0 Background

This Equality Impact Assessment is published alongside the full consultation document available at: https://www.health-ni.gov.uk/consultations/hospitals-creating-network-better-outcomes-public-consultation

1.1 What Is An Equality Impact Assessment?

Schedule 9 of the Northern Ireland Act 1998 provides for a comprehensive consideration by public authorities of the need to promote equality of opportunity, giving effect to Section 75 of the Act, between:

- People of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- Men and women generally;
- People with a disability and people without one; and
- People with dependants and people without dependants.

These are called 'Section 75 Groups' because the relevant law is Section 75 of the Northern Ireland Act 1998. In addition, without affecting the above duty, public authorities must have regard to the desirability of promoting good relations between people of different religious beliefs, political opinions and racial groups.

Equality Schemes must be prepared, which among other things must set out arrangements for assessing the likely impact on the promotion of equality of opportunity of the policies adopted or proposed.

Where equality impacts are likely to be major, a public authority needs to undertake an Equality Impact Assessment (EQIA). This is "a thorough and systematic analysis of a policy, whether the policy is written or unwritten, formal or informal, and irrespective of the scope of the policy or the size of the public authority."

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As part of the assessment, consideration must be given to anything that could reduce any adverse impact on equality of opportunity of the policies proposed. Thinking through what opportunities exist to better promote equality must also be a part of the assessment. Consideration to alternative policies that might better promote equality of opportunity must also be given.

1.2 Policy Overview:

The purpose of the consultation, including this EQIA is to support widespread engagement with communities, clinicians, and society as a whole on **Why** we need to reconfigure our Hospitals; **How** we will manage our hospital system as an integrated network; **What** pathways there are for citizens to access hospital services and how they can travel there; **Where** those services are and will be delivered; and **When** future service reviews will take place to inform future reconfiguration. This will become the basis and strategic context for current and future service reconfigurations.

Why Change Is Coming

The way health and social care is provided in Northern Ireland has evolved over the last few decades. Advances in medicine and changes in the health needs of our population necessitate a reconfiguration of our hospital services. People are living longer, and with an ageing population comes increased demand for healthcare services. By mid-2045, the population aged 65 and over is projected to increase by 56.2%, from 326,500 in mid-2020 to approximately 509,600[1].

The Need for Reconfiguration

Our current hospital infrastructure has not kept pace with these changes. Spreading key services too thinly over too many sites has led to workforce challenges, including difficulties in recruitment and retention, and issues with maintaining safe staffing levels. The reconfiguration aims to:

- Deliver safe and better health and social care services, supported by best practice standards.

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- Ensure equal access to healthcare across Northern Ireland and reduce health inequalities.
- Improve the effectiveness and efficiency of services, making the best use of available funding and our workforce.
- Achieve financial sustainability in health and social care services.
- Create a resilient service that reduces reactive safety-related service changes.

Addressing Health Inequalities

Health inequalities in Northern Ireland are a significant concern. Variations in health outcomes are closely linked to socio-economic status, geographic location, and other social determinants of health. People living in the most deprived and rural areas experience worse health outcomes, including higher rates of chronic illness and lower life expectancy[2]. The reconfiguration aims to reduce these inequalities by ensuring equal access to high-quality healthcare services across the region.

Hospital Categorisation

The new network structure categorises hospitals in Northern Ireland into four specific main types, operating as an integrated network:

1. **Local Hospitals**: Delivering primary, secondary, and community services in support of area and general hospitals.

2. **General Hospitals**: Delivering defined secondary care services, including unscheduled care, geared to specific, more isolated geographical locations.

3. **Area Hospitals**: Delivering a full range of secondary care services, both unscheduled and elective, to communities within a geographical area.

4. **Regional Centres**: Delivering specialist regional inpatient services for the entire population of Northern Ireland.

Elective Care

The new network initiative introduces Elective Care Centres of Excellence to deliver high-quality care. These centres aim to increase productivity, efficiency, and

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reliability, significantly impacting the number of patients treated. Some reconfiguration has already begun, with day procedure centres at Lagan Valley and Omagh Hospitals, and elective overnight stay centres at the Mater Hospital, Daisy Hill Hospital, and South West Acute Hospital.

1.3 Impacts on People and Scope of the Equality Impact Assessment

The EQIA shows that some equality groupings are likely to have particular needs in relation to the reconfiguration of hospital services, and this is explored in this EQIA.

The total population in Northern Ireland, including people in the Section 75 categories, is expected to benefit from the proposals.

Considering Health Inequalities

The reconfiguration policy is mindful of existing health inequalities in Northern Ireland. By redesigning services to be more accessible and efficient, particularly in underserved and rural areas, the policy aims to reduce disparities in health outcomes between different socio-economic groups and geographic locations.

1.4 Staff groups

Specific engagement with Trade Unions and staff groups is an important element of any reconfiguration. DoH continue to engage with Trade Unions and Royal Colleges as part of this work. However, Trusts, as employers, will have responsibilities to manage staff issues in line with best practice and pre-existing regional policies and agenda for change terms and conditions. These issues will be explored in detail through partnership working with staff groups and trade unions and human resource experts.

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1.5 Scope Summary

This EQIA is concerned with the equality implications of the strategic policy direction for creating a hospital network in Northern Ireland; with regards to actual and potential users of the service, their families; their carers and the population. It also examines the impact on HSC staff.

Longer term decisions on implementation of the recommendations have yet to be taken. Final decisions will be subject to further engagement and consultation at a local and regional level as required. Equality considerations must be set in this context.

2.0 Data Collection

In line with the Equality Commission (NI) guidelines, data from various sources have been used to prepare this EQIA, including quantitative statistics from NISRA and qualitative insights from stakeholder engagement undertaken during the development of this consultation document and from previous engagement and public consultation that was undertaken during policy development that shapes these proposals. A full reference list can be found at the end of this document.

This EQIA is concerned with the equality implications of, with regards to actual and potential users of the service and their carers. It also examines the impact on staff.

The document being consulted on has been prepared using co-production and involvement methodology. DoH has brought together people with lived experience and healthcare professionals from across all Health and Social Care Trusts (HSC), Public Health Agency (PHA), Primary Care, policy makers, community and voluntary sectors.

In preparing this EQIA, the findings from a range of data and research sources were taken into account:

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- Quantitative data (statistical information) to provide a first overview of the characteristics of those people most likely to be affected by the policy, including statistics from the Northern Ireland Statistics and Research Agency;
- Qualitative data gathered from research, academic literature and workshops also provides insights into perceptions held by those who are likely to be most affected as well as suggestions for improvement.

Targeted pre-consultation with service users, carers, Trade Unions and Royal Colleges, has also shaped the content and the actions outlined of the consultation document.

During the full consultation period for this EQIA, the Department will continue to undertake engagement with a range of stakeholders as appropriate

3.0 Key Findings

Equality of Opportunity

This section outlines our key findings across the nine equality groups outlined in Section 75(1) of the Northern Ireland Act:

1. Gender
2. Age
3. Religion
4. Political opinion
5. Marital Status
6. Dependant Status
7. Disability
8. Ethnicity
9. Sexual Orientation

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3.1 GENDER

Demographic Data

The total population of Northern Ireland is approximately 1,903,100 individuals[1]. Of this population, 966,500 are female (50.8%), and 936,600 are male (49.2%)[1].

The HSC workforce reflects a significant gender disparity, with women constituting 81% (approximately 54,837) and men 19% (approximately 12,863) of the total 67,700 employees[2].

This representation indicates that changes in service delivery may disproportionately impact female staff, particularly those with caring responsibilities.

Impact Analysis

Women are more frequent users of healthcare services, particularly in reproductive health and maternity services. As the World Health Organization notes, "Gender norms and values can influence health-seeking behaviour and access to services"[3]. Women also predominantly assume caregiving roles, with approximately 61% of carers in Northern Ireland being female [4]. According to Carers UK, "58% of carers are women, and they are more likely to provide higher levels of care"[4].

Service Users

Changes such as centralising facilities may disproportionately affect women due to:

- Increased Travel Times: Centralisation could lead to longer journeys, impacting access to timely care, especially for maternity services[5].

- Caregiving Responsibilities: Women balancing employment with caring duties may find it challenging to accommodate additional travel or changes in service locations[4].

Workforce

The high number of female staff means organisational changes could significantly impact women. The Royal College of Nursing highlights that "flexible working is crucial for retaining nursing staff who may have caring responsibilities at home"[6].

Potential impacts include:

- Work-Life Balance: Changes in work locations or shift patterns may disrupt personal responsibilities.

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- Career Progression: While centralised services may offer advancement opportunities, they may also require relocation, which can be a barrier for those with familial ties.

Mitigation

To mitigate potential impacts on gender in the hospital network, several key actions will be implemented. Action 1 involves the Department working with other NI Executive Ministers to assess travel support available to the population. Action 2 entails a review of the 2007 Transport Strategy for Health and Social Care services. HSC Trusts (Action 3) will evaluate how local hospitals can sustainably meet community needs, while staff will be involved in planning (Action 4) to collaboratively address concerns. Action 6 focuses on assessing resource allocation across Area Hospitals to reduce inequities in access to services. While Action 10 introduces a rolling programme of workforce reviews to ensure staff are adequately trained and supported. These actions aim to promote a more equitable and accessible healthcare system for all.

3.2 AGE

Demographic Data

Individuals aged 65 and over constitute approximately 17% of the population, numbering around 323,700 people[1]. The ageing population is projected to increase by 25% by 2039, leading to a higher demand for health services[7].

The number of people aged 85 and over is projected to double by mid-2045[8]. Data from NISRA Population Projections highlights a significant projected increase in the population aged over 65 and over 85, which will create new demand requirements in the management of multi-morbidity:

- The overall population of NI is expected to grow by 63,772 between 2023 and 2043 (3% increase).
- The population of 0-14 year-olds is projected to decrease by 11% between 2023 and 2043 (a decrease of 39,897).
- The population aged 65 years and older is expected to increase by 41% over the period 2023 to 2043 (an increase of 139,047).
- The population aged 85 years and older is projected to increase by 77% over the period from 2023 to 2043 (an increase of 33,162).

Children and young people (aged 0-17) constitute approximately 23% of the population[1].

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Children and young people require specialised healthcare services, and changes in service locations could significantly impact their access to paediatric care. The 2021 NISRA Census indicates that approximately 21% of the Northern Ireland population is aged 16 and under, underscoring the critical need for accessible healthcare for this demographic[1]. Research from the Children's Commissioner for Northern Ireland highlights that geographical barriers, particularly in rural areas, can hinder access to specialized services, with around 15% of rural children facing difficulties in obtaining necessary healthcare[9].

In the HSC workforce, 41% of all staff were under the age of 40; 26% were between 40 and 49, and 33% were over 50[10].

Impact Analysis

Service Users

Older people have higher healthcare needs due to chronic conditions. Age NI states, "Approximately 80% of older people have at least one chronic condition"[11].

Key concerns include:

- Accessibility Issues: Mobility impairments can hinder access to centralised services. Disability Action notes, "Transport remains a significant barrier for many disabled and older people"[12].

- Digital Exclusion: Older adults may be less familiar with telehealth technologies. Ofcom reports that "only 47% of those aged 75 and over use the internet"[13].

- Paediatric Services: Changes may affect access to specialised care. The NSPCC warns, "Reduced access to paediatric services can have long-term effects on children's health"[14].

- Mental Health: Young Minds reports that "one in eight children have a diagnosable mental health disorder"[15].

Workforce

Older staff may face challenges adapting to new technologies or work practices. NHS England emphasises the importance of supporting older staff: "Tailored training and development opportunities can help retain valuable experience within the workforce"[16].

Mitigation

To address potential impacts on different age groups, including older individuals and children and young people, several key actions will be implemented. Action 1 involves the Department working with other NI Executive Ministers to assess travel support. Action 2 entails a review of the 2007 Transport Strategy. HSC Trusts

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(Action 3) will evaluate how local hospitals can meet the specific needs of these populations. Action 4 emphasises collaboration among HSC Trusts to maintain core General Hospital services. Action 6 will assess resource allocation across Area Hospitals to minimize inequities, particularly for rural communities. Action 10 introduces a rolling programme of workforce reviews focused on disability awareness and support. These actions aim to create more equitable decisions for all age groups.

3.3 RELIGION

Demographic Data

The population of Northern Ireland consists of 45.7% identifying as Catholic, 43.5% as Protestant and other Christian denominations, and 10.8% with other or no religion[1]. Approximately 82% of the population identifies as Christian, while about 2.7% belong to other religions or no religion at all[1].

Impact Analysis

Service Users

Religious beliefs may lead to difficulties in accessing culturally appropriate healthcare services. Approximately 21% of individuals from minority religions reported such challenges[17].

- Treatment Preferences: Certain religions have specific guidelines regarding medical interventions[16].

- Dietary Requirements: Religious dietary laws may dictate hospital meal planning[19].

- Religious Minorities: May require specific accommodations or considerations in healthcare settings.

Workforce

The most recent data from the Health and Social Care Workforce Census indicates that the religious composition of HSC staff in Northern Ireland is as follows: approximately 46% identify as Catholic, 43% as Protestant and other Christian denominations, and around 11% belong to other religions or identify with no religion. These statistics reflect the wider composition of the population, however there is growing diversity in the workforce and this will continue to be measured.

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Mitigation

To address the identified potential impacts on service users from diverse religious backgrounds, several key actions will be implemented. The Department will collaborate with other NI Executive Ministers/Departments to assess travel support available to the population (Action 1), ensuring accessibility. Additionally, sustainable resource allocation across Area Hospitals will be considered to minimize inequities in access to services (Action 6). A rolling programme of specialty-specific workforce reviews will also continue, focusing on providing staff with training in religious sensitivity (Action 10). These actions aim to create a more inclusive healthcare environment.

3.4 POLITICAL OPINION

Specific data on political opinion is not collected, however, it is recognised that political affiliation often correlates with religious background in Northern Ireland[18].

Impact Analysis

Service Perception: Ensuring neutrality is vital. The Northern Ireland Life and Times Survey indicates that "trust in public services can be influenced by perceptions of political bias"[20].

Mitigation

We will continue to assess this issue and assess if there are mitigating actions we can identify.

3.5 MARITAL STATUS

Demographic Data

Approximately 48% of the population is married, while 36% are single[1].

Impact Analysis

Service Users

Married people may have different healthcare needs compared to singles or cohabiting partners, especially in relation to family health dynamics and decision-making.

Marital status can influence support networks:

- Single Individuals: May lack immediate family support when accessing healthcare[20].

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- Widowed or Divorced: May experience isolation affecting their health outcomes.

Mitigation

We will continue to assess this issue and assess if there are mitigating actions we can identify.

3.6 DEPENDANT STATUS

Demographic Data

There are approximately 220,000 unpaid carers in Northern Ireland, representing 12% of the population[1]. Carers NI highlights that "one in eight adults provide care for a family member or friend"[21]. Within the HSC workforce, about 35% have caring responsibilities[22].

Dependants, including children, elderly relatives, or individuals with disabilities, significantly affect healthcare access and family dynamics. Approximately 15% of households in Northern Ireland contain dependants under the age of 16 [1]. Additionally, many of these households are led by caregivers who provide essential support to their dependants.

Impact Analysis

Service Users

Caregivers: Those responsible for dependants may find it increasingly difficult to manage their caregiving responsibilities if access to healthcare services becomes more complicated due to changes in service delivery. The need for flexible service options is critical to support caregivers.

Dependants: Caregivers may face challenges in balancing their responsibilities with accessing necessary health services for themselves and their dependants, which can lead to increased stress and potential deterioration in health outcomes.

Individuals with dependants may experience barriers to accessing healthcare, particularly if service changes lead to increased travel or require additional support. Caregivers often face unique challenges, including managing their own health needs while balancing the care of their dependants. The pressures on working carers can be present, as they must navigate their job duties as well as caregiving duties.

Issues may include:

- Time Constraints: "Many carers struggle to find time for their own health needs due to their caring role"[23].

- Health Risks: The Mental Health Foundation reports that "carers are more prone to depression and anxiety"[24].

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Centralising services may impact these issues by increasing travel times and reducing accessibility.

Workforce

Approximately 28% of the Health and Social Care (HSC) workforce identifies as having caring responsibilities[10]. This dual role can create challenges for staff, as balancing professional responsibilities with caregiving can lead to increased demands on their time and energy.

Mitigation

To mitigate the potential impacts identified, the Department will collaborate with other NI Executive Ministers/Departments to thoroughly evaluate the travel support options available for the population (Action 1). Ongoing assessments will be conducted to identify any additional mitigating actions that can be taken.

3.7 DISABILITY

Demographic Data

Approximately 21% of the population have a disability or long-term health condition[1]. Disability Rights UK notes that "disabled people are more likely to experience barriers in accessing healthcare"[25]. This includes conditions that may require ongoing support or adaptations to service delivery.

In the HSC workforce, around 6% report having a disability[2].

Impact Analysis

Service Users

People with disabilities may face barriers in accessing health services, especially if reconfiguration leads to longer travel distances or inadequate facilities.

Issues include:

- Physical Accessibility: "Inaccessible healthcare facilities can deter disabled people from seeking care"[25].

- Communication Needs: Action on Hearing Loss highlights that "over 70% of people who are deaf have difficulty communicating with healthcare staff"[26].

Creation of a hospital may have a differential impact on this group, however this will be specific to each person and what hospital services they require.

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There is limited data on the profile of the Health and Social Care (HSC) workforce in terms of disability. However, NHS Workforce Disability Equality Standard (WDES) [27] continues to provide insights into this area.

As of the most recent reports in 2023, NHS England has been actively working to improve data accuracy and representation of staff with disabilities. This involves utilizing updated national datasets:

- The 2023 NHS Staff Survey, which engaged over 600,000 staff members, providing valuable insights into the experiences and challenges faced by NHS staff.[28]
- The Electronic Staff Record (ESR), which remains a comprehensive source of workforce data for planning and management.

Recent findings indicate that disability representation among NHS staff is improving, with approximately 24% reporting a disability in the 2023 NHS Staff Survey. This increase is attributed to better reporting practices and awareness. However, the ESR still reports lower figures around 5%, indicating the need for ongoing enhancements in data collection and self-reporting practices.

Discrepancies between the datasets arise from:

1. Different definitions of disability used in each dataset.
2. Variations in the conditions for self-disclosure, particularly with the NHS Staff Survey being anonymous.
3. Timing of disability disclosure, as ESR data may not be consistently updated after initial staff appointments.

These findings highlight the importance of continuous data refinement and the development of strategies to support NHS staff with disabilities effectively.

The difference in reported disability levels between these datasets can lead to challenges in workforce planning and support for staff with disabilities. Variations arise due to different definitions of disability, the anonymous nature of the NHS Staff Survey, and the timing of disclosure, as ESR data may not be consistently updated.

Mitigation

To mitigate barriers to hospital services for people with disabilities, Action 1 focuses on enhancing travel support, ensuring they can access healthcare facilities. Action 6 aims to allocate resources to minimize access inequities, directly benefiting disabled individuals. Action 3 encourages local hospitals to meet community needs, improving localized access. While, Action 13 promotes provider collaboration, strengthening the hospital network to offer consistent services for those with disabilities.

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3.8 ETHNICITY

Demographic Data

Minority ethnic groups constitute a small yet notable segment of the population, comprising approximately 3.4%, with Asian individuals at 1.8%, Black individuals at 0.2%, and those of Mixed ethnicity at 1% [1]. This demographic diversity underscores the importance of cultural awareness and sensitivity in service provision and accessibility.

Within the Health and Social Care (HSC) workforce, about 5% of the staff are from Black and Minority Ethnic (BME) backgrounds [2]. This diversity is crucial for delivering culturally competent care and understanding the unique needs of a diverse patient population.

Impact Analysis

Service Users

Language and cultural barriers can impede access to healthcare:

Language Support: "Patients with limited English proficiency may struggle to communicate their needs"[29].

Cultural Competence: Understanding cultural differences is crucial for effective care. NHS England notes, "Culturally competent care can improve patient satisfaction and health outcomes"[30].

Potential Impact

Ethnic Minorities: May face challenges in accessing services due to language barriers or cultural insensitivity within the healthcare system.

Mitigation

To mitigate the potential challenges faced by ethnic minorities in accessing healthcare services, several strategic actions from the policy document will be implemented. One initiative involves collaboration with other Northern Ireland Executive Ministers/Departments to thoroughly evaluate and enhance the travel support options available to the population, ensuring that transportation does not become a barrier to healthcare access. Furthermore, a comprehensive assessment will be conducted to determine the most sustainable allocation of resources across Area Hospitals. This aims to promote a more equitable healthcare system by minimising disparities in service access, thereby improving the overall quality of care for all community members.

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3.9 SEXUAL ORIENTATION

Demographic Data

Estimates suggest that LGBTQIA+ individuals represent 6-10% of the population, equating to 114,000 to 190,000 people[35]. Within the HSC workforce, around 5% identify as lesbian, gay, bisexual, or other[2].

Impact Analysis

Service Users

People may face stigma or discrimination in healthcare settings, affecting their willingness to seek care. A study found that 31% of LGBTQ+ individuals reported avoiding healthcare due to fear of discrimination[31].

Potential Impact
- LGBTQ+ Individuals: May be deterred from accessing services due to fear of discrimination or lack of understanding from healthcare providers.
LGBTQIA+ individuals often face health disparities:

- Mental Health: Stonewall's report indicates that "52% of LGBT people experienced depression in the last year"[32].

Service Avoidance: "One in seven LGBT people have avoided treatment for fear of discrimination"[33].

Mitigation

We will continue to assess this issue and assess if there are mitigating actions we can identify.

4.0 Disability Duties

Section 75 of the Northern Ireland Act 1998 and Section 49A of the Disability Discrimination Act 1995, require public authorities, including the Department of Health, to have due regard to:

- promote equality of opportunity between people with a disability and people without (Section 75)
- promote positive attitudes towards people with a disability (Section 49A)

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- encourage the participation of people with a disability in public life (Section 49A)

This means that when making decisions and policies and setting priorities, public authorities must give serious consideration to these three goals and consider taking suitable action to achieving them.

The Disability Discrimination Act 1995 bans disability discrimination by employers against jobseekers and employees with disabilities, and by service providers against service-users with disabilities.

It places a duty on employers and service providers to make reasonable adjustments for people with disabilities to help them to overcome barriers they may face in gaining and remaining in employment and in accessing and using goods and services.

DDA Considerations

The hospital network proposals are designed to align with the Disability Discrimination Act (DDA) by ensuring that all health services are accessible to individuals with disabilities. The framework emphasizes the importance of equal access to healthcare across Northern Ireland, recognizing that some citizens may need to travel further to receive quality care based on their clinical needs. By incorporating accessibility features in hospital facilities and actively engaging with communities, the proposals aim to foster a supportive environment that encourages the participation of individuals with disabilities in all aspects of hospital services. Additionally, the commitment to staff training and awareness initiatives will promote positive attitudes towards individuals with disabilities, ensuring that their needs are prioritized in the reconfiguration of services.

5.0 Good Relations

We have identified no major issues impacting on good relations.

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6.0 Human Rights

As part of the Equality and Human Rights Impact Assessment (EQIA) we also conduct screening to ensure we comply with the Human Rights Act 1998. This Act, which incorporates the European Convention on Human Rights into law, guides our commitment to ensuring that healthcare policies respect fundamental rights such as the right to life, respect for private and family life, and prohibition of discrimination.

The screening exercise highlighted that some proposals in 'Hospitals – Creating A Network For Better Outcomes' may have a potential impact on:

1. **Article 2: Right to Life** - Ensures access to timely medical treatment. Changes in hospital services could affect life-saving care availability.
2. **Article 8: Right to Respect for Private and Family Life** - Considers the impact on family dynamics and care coordination, especially for those with dependents, due to changes in healthcare services.
3. **Article 14: Prohibition of Discrimination** - Ensures equitable access to healthcare, preventing disproportionate impacts on certain groups based on race, gender, disability, or socio-economic status.

All other Articles have been assessed as neutral impact.

Mitigation

To uphold the Right to Life (Article 2), we will work with other NI Executive Ministers/Departments to enhance travel support, ensuring timely healthcare access. Revisiting the 2007 Transport Strategy will help remove barriers to essential care.

We aim to adapt local hospitals to community needs which is in alignment with Article 8, which respects private and family life, This ensures that healthcare delivery supports family dynamics, particularly for those with dependents.

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We aim to strategically allocate resources across Area Hospitals to minimize access inequities. Designating hospitals as an elective care centre and reallocating activities supports fair resource distribution. Taking this approach is intended to prevent discrimination and ensure equitable service provision in line with Article 14.

Our focus on clinical training and workforce development ensures healthcare professionals are prepared for evolving health needs, supporting sustainable, non-discriminatory services.

By promoting equitable access, family support, and preventing discrimination, we aim to provide a healthcare system that is timely, safe, and sustainable, fostering population well-being and network efficiency.

7.0 Conclusions

This EQIA had used available evidence to consider all 9 Equality groupings. It is evident that this proposed strategy may impact the groups below:

Gender
Age
Dependant Status
Disability

This Draft EQIA highlights a range of mitigating actions that would address the inequalities identified. As part of the consultation process we invite stakeholders to consider the information included within this Draft EQIA and associated consultation documents and provide feedback and relevant information to shape the future of services. If you have any questions or would like to discuss this Draft EQIA please contact us at .

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8.0 Proposed Monitoring

Consultation responses will be identified and categorised, where possible, according to key Section 75 issues that may be highlighted.

9.0 Feedback

Additional comments are welcomed specifically as they relate to this Draft EQIA.

Questions on the EQIA will be included in the main consultation questionnaire. You can also share your feedback with us via contact details provided on page 2 of this document.

If you have any questions or would like to discuss this Draft EQIA, please contact us by e-mail at: rebuildinghsc.services@health-ni.gov.uk or by post at:

Transformation Branch
Regional Health Services, Transformation Directorate
Department of Health NI
Annex 3, Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ
Northern Ireland

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